NOTICE OF INDEPENDENT REVIEW DETERMINATION

MDR Tracking Number: M2-03-1812-01

September 17, 2003

An independent review of the above-referenced case has been completed by a doctor board certified in family practice. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by ___, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

___ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to ___.

CLINICAL HISTORY

___ apparently sustained a work related injury on ___. A patient progress report notes pain relief using the muscle stimulator. ___ submits two form letters dated 6/6/03 which one documents good results with the device while the other states excellent results. The prescriptions for the muscle stimulator noted prior treatment with PT and medications. No records were submitted documenting the original injury or treatment including physician records, therapy, or pharmacy records. No TWCC forms were forwarded. Two orthopedic surgeons denied the purchase of the requested device.

REQUESTED SERVICE(S)

Purchase of an interferential muscle stimulator.

DECISION

Uphold prior denial.

RATIONALE/BASIS FOR DECISION

Patient sustained a work related injury diagnosed as lumbago on 10/31/97. Documents suggest a good or excellent response to a muscle stimulator from 4/30/03 through 6/6/03. There are no medical records to substantiate the patient's response to this device or other treatments. In addition, no accepted peer reviewed double blind, placebo studies or community standard of care support the use of this type of device for the diagnosis of lumbago over five years after the original injury. Therefore, the original decision for denial is upheld.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) calendar days of your receipt of this decision (20 Tex. Admin. Code 142.5©).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) calendar days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings/Appeals Clerk
Texas Workers' Compensation Commission
P.O. Box 17787
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 17th day of September 2003.